



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

NUEVA VIDA BEHAVIORAL HEALTH

**Respondent Name**

ASSOCIATION CASUALTY INSURANCE

**MFDR Tracking Number**

M4-14-3384-01

**Carrier's Austin Representative**

Box Number 53

**MFDR Date Received**

July 11, 2014

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Prior Authorization was obtained for all services we provided, which were medically necessary in aiding the patient recovery for the work related compensable injury (see attached preauthorization letter). As stated by the Physician Advisor in the preauthorization letter, 'The request for individual psychotherapy 6 sessions over 6 weeks is recommended as medically necessary; Current evidence based guidelines support an initial trial of 6 sessions of individual psychotherapy to establish efficacy of treatment.'

**Amount in Dispute:** \$898.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "There is an unresolved issue regarding the extent of the compensable injury and therefore this request should be dismissed pursuant to 28 TAC 133.307(f) (3) (C). In addition, enclosed please find the PLN-11s filed in this matter along with the report of designated doctor Ramesh Shah, M.D. and Andrew Brylowski, M.D. which support the Carrier's position regarding the extent of injury issue."

**Response Submitted by:** Hoffman Kelley L.L.P.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 2, 2014, January 23, 2014, March 6, 2014, March 13, 2014, March 27, 2013 and April 3, 2014	90837 x 6	\$708.00	\$708.00
February 5, 2014 and March 6, 2014	90885 and 96152	\$190.00	\$0.00
TOTAL		\$898.00	\$708.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.305 sets out the general Medical Dispute Resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.
4. 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
5. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W9 – Unnecessary medical treatment based on peer review.
  - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

### **Issues**

1. Did the insurance carrier submit documentation (EOBs) to support the denial of extent raised in the position summary?
2. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of medical necessity for disputed CPT codes 90885 and 96152 rendered on February 5, 2014 and March 6, 2014?
3. Did the requestor submit documentation to support that the disputed services were preauthorized by the insurance carrier?
4. Is the requestor entitled to reimbursement?

### **Findings**

1. To determine whether such an extent-of-injury or related dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Tex. Admin. Code § 133.240(e), (e)(1), (2)(C), and (g) addressed actions that the insurance carrier was required to take, during the medical billing process, when the insurance carrier determined that the medical service was not related to the compensable injury: 31 TexReg 3544, 3558 (April 28, 2006). Those provisions, in pertinent parts, specified:

Former 133.240(e), (e) (1), (2) (C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division.... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was: ... (C) unrelated to the compensable injury, in accordance with § 124.2 of this title... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code § 409.021, and § 124.2 and 124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that: (3) the condition for which the health care was provided was not related to the compensable injury.

Review of the submitted documentation finds that the insurance carrier submitted insufficient documentation to support the denial of extent of injury raised in the position summary; as a result, the disputed charges are reviewed pursuant to the applicable rules and guidelines.

2. The medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of medical necessity for CPT codes 90885 and 96152 rendered on February 5, 2014 and March 6, 2014. Reviews of the EOBs presented by the requestor indicate denial reason code "W9 – Unnecessary medical treatment based on peer review."

**Resolution of a Medical Necessity Dispute:** The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at [http://www.tdi.texas.gov/hmo/iro\\_requests.html](http://www.tdi.texas.gov/hmo/iro_requests.html) under **Health Care Providers or their authorized representatives.**

**Notice of Dispute Sequence:** 28 Texas Administrative Code §133.305(b) requires that “If a dispute regarding...medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding...medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021.

The division finds that CPT codes 90885 and 96152 rendered on February 5, 2014 and March 6, 2014 are not eligible for review due to the unresolved medical necessity issues.

The CPT codes 90885 and 96152 rendered on February 5, 2014 and March 6, 2014 may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

3. Per 28 Texas Administrative Code §134.600 “(p) Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program.”

The requestor submitted multiple copies of two preauthorization letters issued by Forte. The first preauthorization letter dated November 22, 2013 recommended preauthorization for outpatient individual psychotherapy (IPT) six (6) sessions over eight (8) weeks from 11/22/13 – 1/31/14.

The requestor seeks reimbursement for CPT code 90837 defined by the AMA CPT Code book as “Psychotherapy, 60 minutes with patient and/or family member.” Review of the submitted documentation supports that preauthorization was obtained for dates of service January 2, 2014 and January 23, 2014, as a result, the insurance carrier’s denial of unnecessary medical is not supported and the disputed services are reviewed pursuant to 28 Texas Administrative Code §134.203 (c).

The second preauthorization letter dated March 10, 2014 recommended authorization of six (6) sessions of outpatient individual psychotherapy (IPT) over eight (8) weeks (03/10/14 – 05/10/14). Review of the submitted documentation supports that preauthorization was obtained for dates of service March 13, 2014, March 20, 2014, March 27, 2014 and April 3, 2014, as a result, the insurance carrier’s denial of unnecessary medical is not supported and these disputed services are reviewed pursuant to 28 Texas Administrative Code §134.203 (c).

4. Per 28 Texas Administrative Code §134.203 “(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year’s conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year’s conversion factors, and shall be effective January 1st of the new calendar year.”

Per 28 Texas Administrative Code §134.203 “(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider’s usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title.”

Procedure code 90837, rendered on January 2, 2014, January 23, 2014, March 13, 2014, March 20, 2014, March 27, 2014 and April 3, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 3 multiplied by the geographic practice cost index (GPCI) for work of 1 is 3. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.916 is 0.43968. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.816 is 0.08976. The sum of 3.52944 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$196.77.

Per §134.203(h), reimbursement is the lesser of the MAR or the provider’s usual and customary charge. The lesser amount is \$118.00/date of service. As a result the requestor is entitled to reimbursement for 6 dates of service at \$118.00 per date of service, for a total recommended amount of \$708.00.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$708.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$708.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
September 18, 2014  
Date

## YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**